SUBMITTED FOR CONSIDERATION UNDER THE UNITED NATIONS COMMITTEE AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

C/- Secretariat, Committee Against Torture
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
8-14 Avenue de la Paix,
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IN THE MATTER OF NEW ZEALAND'S 6th PERIODIC REPORT

SHADOW REPORT - FILED BY 'END SECLUSION NOW'

LIST OF ISSUES FOR THE 54th SESSION

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STATE PARTY:

NEW ZEALAND

1. INTRODUCTION

1. 1. Members and supporters of End Seclusion Now **(ESN)** give thanks to the UN Committee Against Torture for the opportunity to share our comments in connection with the Committee's sixth periodic review of New Zealand during its 54th session, from 20th April to 15th May 2015.

2. SUBMITTING ORGANIZATION

2. 1. End Seclusion Now (ESN) is a mental health campaigning organisation that works to bring about a prompt and decisive end to solitary confinement *(otherwise known as seclusion)* in all of New Zealand's hospitals. The group formed in February 2014 and is active both locally and nationally.

2.2. The group is made up of like-minded individuals and meets the criteria of being a Disability Person's Organisation, with the group comprising almost entirely of persons with psychosocial disabilities, several of whom have experienced the trauma of being placed in solitary confinement during periods of hospital 'care'.

3. THE 'END SECLUSION NOW' CAMPAIGN

3.1. The ESN campaign highlights longstanding concerns of people with psychosocial disabilities[1] regarding the practice of solitary confinement. ESN are working with various other disability persons' organisations and other civil society groups to raise public awareness of the concerns and as part of a strategy to bring about prompt and decisive legislative change.

3.2. The aims of ESN have been to engage with people with disabilites via disability networks, drawing on existing partnerships, as well as social media, and community networking. ESN are attempting to influence the wider mental health and pan disability sector so they will in turn influence Government policy makers.

3.3. ESN's objectives are to bring as much pressure to bear on the Government so that they are persuaded to introduce the inevitable legislation that is required to end the traumatic practice of solitary confinement in hospitals. ESN believes only then can there be an opportunity for the introduction and development of more humane, trauma informed, and therapeutic responses to acute mental health distress, both in the mental health sector, in other social sectors, and within the wider community.

[1] NZ Disabled Person's Shadow Report to the UN CRPD, 2014

4. SCOPE OF SUBMISSION

4.1. This submission is prepared as an introductory paper detailing the State party's violation of fundamental human rights due to the continuing practice of torture brought about by the solitary confinement of people with psychosocial disabilities in New Zealand hospitals. In both community hospitals and forensic hospitals. *[NB: Wherever the term 'seclusion' is referenced in the submission, it is replaced with the more accurate definition of 'solitary confinement']*

4.2. ESN are concerned, but are not appropriately authorised or adequately informed, nor have the expertise to comment on the solitary confinement of:

a. People in institutional facilities deemed to have an intellectual (or learning) disability.
b. People with psychosocial disabilities experiencing solitary confinement in other institutional settings such as correctional facilities (including prisons), group homes, elder care settings, youth facilities (including schools) and other social care institutions.

5. PROPOSED RECOMMENDATIONS TO THE STATE PARTY:

a. To notify the State party that the compulsory detention of people with psychosocial disabilities in solitary confinement constitutes torture, and is evidenced to be cruel, inhuman and degrading treatment or punishment, contrary to Articles 1 of the Convention Against Torture.

b. To implement Article 2 of the Convention Against Torture, by taking all appropriate measures to ensure the absolute prohibition of solitary confinement in all New Zealand hospitals.

c. To introduce legislation immediately under urgency procedures, in order to meet the obligations in Article 2 of the Convention Against Torture.

d. As provided for in Article 4 of the Convention Against Torture, to increase monitoring of institutional facilities, to prevent people with psychosocial disabilities continuing to be placed in solitary confinement in New Zealand hospitals.

e. To make publicly available at the earliest, all data, statistical analyses and related information of any occasion, in which it is known or alleged, that solitary confinement has been used in New Zealand hospitals, and to investigate this within the requirements of Article 10 and Article 20 of the Convention Against Torture.

f. To ensure that education and information is fully included in the (re)training of all persons working in New Zealand hospitals, so as to support the introduction of the absolute prohibition of compulsorily placing a person with a psychosocial disability in solitary confinement.

6. THE PRACTICE OF SECLUSION IN NEW ZEALAND

6.1. Members of ESN have personal and recent experience of being subjected to solitary confinement, and are living proof that the experience is traumatic.

6.2 Despite the imperatives in s71 (2)(a) of the 1992 Mental Health Act as to when solitary confinement can be used, members of ESN have been subjected to seclusion as forms of behaviour management and as punishment.

[NB: For personal accounts of the impact of solitary confinement refer to the ESN 'Our Stories' webpage[2]]

6.3. For more detailed understanding of the implications, procedures, and statistical analysis around the practice of solitary confinement in New Zealand hospitals refer to:

a. The Practice of Seclusion: End Seclusion Now submission to the UN Arbitrary Detention Working Group, 2014.[3]

b. Te Āiotanga: Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals, 2007. [4]

c. Rising to the Challenge, 2012-2017 Mental Health and Addictions service Development Plan.[5]

d. Health and Disability Service Standards, 2009/2010.[6]

e. Director of Mental Health, Annual Reports.[7]

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[2] Personal accounts of the impact of solitary confinement
[3] The Practice of Seclusion in New Zealand: End Seclusion submission to the UN Working Group on Arbitrary Detention, 2014
[4] Te Āiotanga: Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals, 2007
[5] Rising to the Challenge: Mental Health and Addiction Service Development Plan 2012-17
[6] Health and Disability Services Standards, 2009, 2010
[7] Office of the Director of Mental Health Annual Reports

7. UNITED NATIONS CURRENT POSITION

7.1 22nd Session of the Human Rights Council to the UN General Assembly. Report of the Special Rapporteur on Torture statement (2013) [8]:

> **Absolute ban on restraints and seclusion**
>
> *63. The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill treatment. The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment. Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-*consensual *treatment, such as forced medication and electroshock procedures.*

7. 2. Concluding Statement by the UN Working Group on Arbitrary Detention of its visit to New Zealand (24 Mar – 7 Apr 2014).[9]:

> **Detention of Persons with Mental or Intellectual Disabilities**
>
> *The Working Group further expresses its concern relating to the widespread practice of seclusion in psychiatric units. While recognizing the Government's achievement in reducing the incidents of seclusion since 2009, the Working Group urges the authorities to eliminate this practice.*

7.3. The 12th Session of the Convention on the Rights of Persons with Disabilities (CRPD) concluding observation on New Zealand made the following statements in report CPRD/C/NZL/CO/1 (Dec 2014). **[10]** :

> **Liberty and the Person (Article 14. CRPD)**
>
> *30. The Committee recommends the State party take all the immediate necessary legislative, administrative and judicial measures to ensure that no*

[8] 22nd Session of the Human Rights Council to the UN General Assembly. Report of the Special Rapporteur on Torture statement
[9] United Nations Working Group on Arbitrary Detention: Concluding Statement, 2014
[10] 12th Session of the Convention on the Rights of Persons with Disabilities, Dec 2014

one is detained against their will in any medical facility on the basis of actual or perceived disability".

31. The Committee notes that the State party continues to allow the use of seclusion and restraints in psychiatric hospitals. Although there has been a decline in this practice, the situation is not satisfactory.

32. The Committee recommends immediate steps be taken to eliminate the use of seclusion and restraints in medical facilities"

8. ESN RESPONSE TO UN POSITIONS

8.1. ESN see the various UN recommendations on solitary confinement as having been instrumental in engaging the State party with the matters of concern. However, ESN would like to see greater consistency, clarity and certainty in the statements and recommendations made in reports by the various UN bodies, including UN Convention Committees, UN Working Groups and the UN Human Rights Council. By doing so the UN bodies can better protect the inalienable nature of the Human Rights of persons with psychosocial disabilities.

8.2. Take for example the CRPD Committees' recommendations [Article 32, 12th Session]. This failed to provide the same degree of clarity in its reporting on solitary confinement than other UN positions. It only recommended that *"immediate steps be taken",* which is more open to interpretation than the more concise Article 30. recommendation from the same report calling for all *"immediate necessary legislative, administrative and judicial measures*" be taken.

8.3. A further example is the contrast seen in the clarity of statements made by the Special Rapporteur in his report to the Convention Against Torture and the Special Rapporteur from the Working Group on Arbitrary Detention. The Convention Against Torture clearly states "it *is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply*" whilst the report from the Working Group on Arbitrary Detention limits itself to more muted recommendations with comments of "*recognizing the Government's achievement in reducing the incidents of seclusion since 2009, the Working Group urges the authorities to eliminate this practice".*

8.4. ESN prefers the Special Rapporteur on Torture's position as detailed above. ESN prefer the CRPD Committee's recommendations on solitary confinement which states "*immediate necessary legislative, administrative and judicial measures",* which would naturally include solitary confinement which is the most extreme form of arbritary, legislated detention in New Zealand hosptials.

8.5. ESN also welcome UN statements that challenge the practice of a reduction of solitary confinement and agree with the CRPD that this is "*not satifactory".* ESN would like to see greater clarity and consistency from all UN bodies, in their recommendations.

9.THE STATE PARTY'S POSITION(S)

9.1 The State party's report to the 54th Session of the UN Convention Against Torture[11] indicates its current position on the solitary confinement of persons with psychosocial disabilities. ESN see the report details as the:

a. State party complicity in torture due to the endorsement of the continuing practice of solitary confinement.

b. State party relying on legislation to provide it legitimacy in placing people in solitary confinement.

c. Sanctioning the 2009 and 2010 Standards and Guidelines[12] as ways to continue to govern the practice of seclusion.

d. The Ministry of Health's Director of Mental Health 2011 annual report of statistics on mental health treatment, including the use of solitary confinement of people in mental health facilities, *[NB: This report is now out of date with a 2014 report[13] available detailing the 2012-13 period].*

10. CRITIQUE OF THE STATE PARTY'S POSITION(S)

10.1 The State party's report to the 54th Session of the UN Convention Against Torture provides details of how the State party contravenes numerous Articles in both the UN Convention Against Torture and the UN Convention on the Rights of Persons with Disabilities.

10.2 The report indicates the inconsistency, discrepancy and errors in the State party's reporting. The report is limited to the State party's postion on its attempts to reduce solitary confinement rather than to eliminate it. The report omits any mention of the State party's current mental health service development plan, *Rising to the challenge, 2012 – 2017*[14] which does not limit its polices to reduction, but details polies for reduction and elimination of solitary confinement.

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11 State party's report to the 54th Session of the UN Convention Against Torture, Mar 2014
12 Health and Disability Services Standards, 2009, 2010
13 Office of the Director of Mental Health Annual Reports
14 Rising to the Challenge: Mental Health and Addiction Service Development Plan 2012-17

10.3. The State party report states that solitary confinement:

> *288. May sometimes be required to fulfil duty of care and is authorised under sections 60 and 61 of the ID(CC&R) Act and section 71 of the MH(CAT) Act. It may only be used in a forensic hospital level service in accordance with the provisions set out in the MH(CAT) Act and in an area (seclusion rooms) approved by the Director of Area Mental Health Services.*

10.4 This statement is incorrect as the practice is authorised and extensively used in community based hosptial services, not just forensic hosptial level service. It is also wholly incorrect and misleading for the State party to suggest solitary confinement is a practice *"required to fulfil duty of care".*

10.5. The State party's inconsistency, confusion and errors in defining its position on reduction / elimination of solitary confinement, creates uncertainties for service users, and for staff working in the mental health sector. The State party and its representatives continually change the terminology to describe its position on solitary confinement. Policy documentation and service delvery guidelines generally completely omit what has become to be know as the e-word ("*elimination"),* and refer only to reduction. Various State party and District Health Board polices have concurrently described the postions on solitary confinement as:

- Reduction and minimisation of seclusion
- Limit the use of seclusion
- Reduction of seclusion
- Reduction and/or elimination of seclusion
- Reduction or elimination of seclusion
- Reduction towards elimination of seclusion
- Reduction and eventual elimination of seclusion
- Reduction and elimination of seclusion

10.6. There is no evidence in any State party or District Health Board documentation sighted by ESN that indicate human rights obligations are being met by State party documentation by referring solely to elimination.

10.7. Public statements on solitary confinement by the State Party's representatives including the Ministry of Health, District Health Boards[15], and

[15] There are 21 government appointed District Health Board that provide public health services to the community

other Government organisations[16] gloss over the continuing practice of solitary confinement. There is what appears to be a complete denial of current concerns, with an omission of any transparent reporting of breaches of International and National Human Rights legislation, and State party and District Health Board polices.

10.8. Reports invariably highlight the piecemeal progress of reduction if and when it occurs, or the reduction in overall numbers and severity of solitary confinement events. The perspectives of those who continue to experience the trauma of seclusion are omitted from any reporting; particularly those disabled persons who have the view that the practice of solitary confinement should be eliminated forthwith.

10.9. The sanitation of reporting creates a situation in which a culture of coercion, power and control, and secrecy are able to continue, and undermine progressive and genuine attempts to bring about the culture change so needed in mental health service delivery. Such uncertainty is evident even at the senior leadership level of the Ministry of Health with the current Director, Dr John Crawshaw indicating a lack of confidence and certainty in promoting the policy of elimination as set out by his own Ministry. At a networking meeting in 2013 between Dr Crawshaw and DPO representative leaders[17], Dr Crawshaw was asked about the possibility of eliminating seclusion, as stated in his Ministry's 2012-2017 Service Development Plan 'Rising to the Challenge'. Dr Crawshaw's could not confirm his position on elimination but instead stated he had *"a concern that elimination of seclusion might result in an increase of medication being used".*

10.10. The State party and its representatives have an approach of social osmosis, based on an effortless unconscious assimilation of sanitised reporting. It systematically denies a voice to the victims of torture, whilst sanctioning the extensive practice of torture to continue, mostly unabated.

11. DISTRICT HEALTH BOARDS RESISTANCE TO IMPLEMENT POLICY

11.1. In July 2014 ESN sent correspondence to each of the regional District Health Boards via the Chair of their Governance Boards requesting information on what their services where currently doing to meet the State party's policy for the elimination of solitary confinement.

[*NB: APPENDIX 2: ESN correspondence to regional District Health Boards]*

[16] Te Pou article commending Hutt Valley DHB around progress around seclusion contrary to what was commented on by State party appointed District Inspector reports at the time
[17] Reporting of Comments on elimination of seclusion by Director of Mental Health at the Nga Hau E Wha -Ministry of Health networking meeting, 2013

11.2. Of the 21 DHB's, only 4 responded, and of these only two indicated a firm commitment towards policies working to eventually eliminate solitary confinement. One DHB, whom limited their commitment to solely reducing solitary confinement rather than eliminating it, referred to a recent Optional Protocol to the Convention Against Torture investigation as "*giving us a very positive report*". Although this DHB does report rates of solitary confinement in the lower percentile compared to other DHBs, it is of concern that the DHB believes they are justified in continuing the practice based on what they see as positive endorsement from the Convention Against Torture.

12. LONG-TERM FACILITATION OF SOLITARY CONFINEMENT

12.1. The State party is continuing to build new psychiatric facilities in numerous parts of the country, which include cells specifically designed for the purpose of solitary confinement.

12.2. At the official opening of a newly built psychiatric facility in Wellington in 2010, protesters handed out leaflets drawing attention to disabled persons concerns that the facility had called itself a 'Recovery Unit' whilst at the same time having cells to compulsorily detain people in solitary confinement.

[NB: Appendix 3 'Consumers Against Seclusion' Protest leaflet]

12.3. Some Distirct Health Boards are beginning to circumvent the rules governing cells used for solitary confinement in hopsitals by re-designing them in such a way as to be within segregated areas referred to as 'De-escallation' or 'de-esc'. The newly built Wellington psychiatic hospital has a 'De-esc' area which includes 3 cells within a segregated part of the unit. The cells each have a cardboard bedpan, a plastic mattress on the floor with a sheet and pillow, yet no running water or clock and little natural light.

The cells can still officially be used for the purpose of solitary confinment, but the Desc area can also double as a contained 'low stimulus' area, where patients have open access from their cell to a 'communal' area, consisting of two extremely sparse rooms, deviod of natural sunlight, and empty accept for two long padded seats in one room, and a television behind a plastic screen in another. The 'communal' area is under constant surveilance by CCT as well as a small clincal observation office situated in an adjoining room. When the descalation area is in 'lock down' such as at night or during periods when patients are deemed to have become 'escallated' there is no free access to water (other than via staff) or toilet facilites (other than the cardboard bedpan). However, as their cell doors are left open, it is deemed they are not officially in seclusion.

12.4. Patients are often admitted into hospital by going straight into the de-escalation area via a concrete service area referred to as the 'Sally port' *[Dictionary definition: A secure, controlled entryway, as of a fortification or a prison].*

12.5. There is anedotal evidence, that patients have been left in the descalation unit for short periods without staff being available in the observation office. Such incidents are not offically recorded as a solitary confinement (seclusion) events, which consitutes an illegal solitary confinement event and is an example of under-reporting. Keeping two patients in the descalation area, facilitates a reduction in the incidents of reporting of solitary confinement, as when the third person is placed in the Descalation area it is not counted as a solitary confinement event due to others being in the unit. Only once the door to the cell is locked does it become a solitary confinement event.

12.6. There has been anedotal evidence that in this particualr hospital patients have been threatend by other patients whilst in the Descalation area, and that staff are not always able to respond promptly enough. There is also anecdotal evidence that patients have been coerced by staff to accept sedative medication prior to allowing them to exit solitary confinement.

[*APPENDIX 4: Photos of 'Low stimulas' descalation area, including cells used for solitary confinement, and 'Sally Port' used for admission to de-escallation.]*

13. INEFFECTIVE MONITORING OF SOLITARY CONFINEMENT

13.1. ESN are regularly kept informed of numerous individual cases of solitary confinement, in which there have been extensive breaches of both International and National Human Rights legislation[18], as well as cases in which Government and District Health Board policies are continually flouted. Several ESN members provide services outside the group as independent Peer Advocates in high profile cases where people with psychosocial disabilities are experiencing the most extreme breaches of human rights. [19] / [20]

13.2. There are a number of high profile cases that involve people with disabilities being held in seclusion on a semi-permanent basis for long periods, including several cases upwards of 5 years[21]. Media attention of one such case[22] has resulted in human rights monitoring by both the Ombudsman office and the

[18] Redacted case studies will be made available and referred to at the in-session briefings with the rapporteurs and relevant members prior to the examination of the State party's report
[19] Example of the high profile case of a forensic hospital patient currently receiving peer advocacy support
[20] Example of the high profile case of a community based hospital patient currently receiving peer advocacy support
[21] Media Report: Hospital restrains man for six years
[22] Media Report: Mental health patient kept in continuous seclusion

Human Rights Commission. However, we are now two years on from the media attention and the Ombudsman office continues with a 'watching brief', whilst the person is left in a traumatised state in the same cell, in much the same circumstances, accept he is now so conditioned to his circumstances he can no longer spend more than an hour or so a day out of his cell.

13.3. Anecdotal information suggests that psychiatric hospitals are forewarned of visits by auditing services and human rights monitoring organisations such as the Ombudsman office. It is for this reason that patient's families, advocates or other support persons often resort to contacting the media[23]. This may temporarily highlight systematic abuse but generally results in deterioration in relationships between families and hospital clinicians and managers, with evidence that in some circumstances this also results in a deterioration in care provided to patients.

13.4. Reports that are generated from the auditing of each District Health Boards psychiatric hospitals[24] are not consistently reported on, with some DHBs reporting on their audit of the process and environmental requirements of solitary confinement[25] whilst other DHB's failing to report at all on the auditing of solitary confinement[26]. The auditing information that can be accessed publicly is generally quantitative and brief, providing little qualitative analysis of the practice of solitary confinement.

13.5. The auditing guidelines[25] require patients, their families and their carers to be included in the gathering of information and feedback on the quality of service delivery. However, as far as we are aware this has never included those who have experienced solitary confinement, further limiting transparency and skewing State party satisfaction statistics.

13.6. The Director of Mental Health annual reporting[27] provides the higher-level, publicly available access to the most recent, statistics and data analysis of solitary confinement events, trends and demographic data. These reports lack transparency, as data provided for the reports cannot be publicly accessed, limiting independent verification of data. Further more, the report has significant reporting delays prior to publication (at least 1-2 years).

13.7. The Director of Mental Health's reporting on solitary confinement lacks accountability, as there are ineffective opportunities for disabled people and their organisations to provide comment, and to have these included in the report.

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[23] Media report: Allegations of systematic abuse whilst in solitary confinement
[24] Guidelines for District Health Boards: Mental Health Quality Monitoring and Audit
[25] Example of a District Health Board report on the auditing of solitary confinement
[26] Example of a District Health Board failing to report on the auditing of solitary confinement
[27] Latest Director of Mental Health annual report, 2013

13.8. The reports do not provide an opportunity for disabled persons and their organisations to provide their own independently verifiable data, further limiting the credibility of the reports. While there is a small amount of comment in the Director of Mental Health's report by disabled people, the State party representatives determine this, with a focus on 'success stories', rather than any comment, which would indicate a negative critique of service delivery. There is no comment from disabled persons at all on the experience of solitary confinement. Where there is comment regarding other coercive measures that also contravene UN Conventions (eg; Compulsory Treatment Orders) there is only positive comment from disabled people, despite this being extensively and adversely commented on within online disability networks.

13.9. Qualitative reporting on solitary confinement events is difficult to publicly access, and the information that is available is insufficient in detail, particularly around demographic information of victims, staffing and other resourcing constraints, and debriefing information such as the before, during and after contexts of seclusion events.

13.10. Some information is accessible via redacted District Inspectors' reports[25], that investigate breaches of legislation such as unauthorised solitary confinement events and/or transgressions of policies around the administration of solitary confinement. However, these are generally not publicly available due to District Inspectors not complying with requests to provide redacted copies that protect individual privacy.

13.11. In conclusion, concerning the monitoring of solitary confinement, there lacks a robust independent process that fully investigates both the nature and extent of problems associated with the practice, and the problems associated with the inherent resistance to the Ministry of Health's policy of elimination by some clinicians and others opposed to its introduction.

14. UNDER REPORTING OF HUMAN RIGHTS BREACHES BY THE STATE PARTY

14.1. There is evidence of significant under reporting and misrepresentation of information concerning the unauthorised use of solitary confinement and/or transgressions outside of what is provided for in local District Health Board policies. Evidence has been provided to ESN via anecdotal reports from service users, independent Advocates, Welfare Guardians and family support persons, DPOs, as well as posted online via social media disability persons networks.

14.2. Other sources of evidence of under reporting and misrepresentation have come via Human Rights lawyers that have provided legal representation to

disabled people, official inquiries and investigations commissioned by State party representatives[28], and within District Inspector reports[29].

15. DISPROPROTIONATE USE OF SOLITARY CONFINEMENT OF MAORI

15.1. The final word in this submission is of the greatest concern amongst all the concerns raised in this submission; the disproportionate use of solitary confinement of Māori, which is evidence of discrimination, and contrary to the United Nations Committee on the Elimination of Racial Discrimination. Based on the latest statistics in the Director of Mental Health's Annual Report [30], Maori were 3.7 times more likely to be placed in solitary confinement than other ethnic groups.

15.2. It is a travesty that the percentage of Maori to other ethnic groups being placed in solitary confinement has actually increased in the last two reporting periods, rising from 32% in 2012 to 36% in 2013. It is of great concern that the Director of Mental Health did not refer to this deterioration in his latest report. The lack of statistical information, trend analysis and reporting of this deterioration in the Directors report demonstrates the State party's selective approach to presenting current trends and analysis. The paucity of any effective monitoring, service delivery changes, and policy development, by the State party to address this discrepancy so as to meet its Treaty of Waitangi obligations demonstrates a lack of leadership and accountability on the part of the State party.

15.3. In its concluding statement after its visit to New Zealand in early 2014, the United Nations Working Group on Arbitrary Detention reminded the State party that the United Nations Committee on the Elimination of Racial Discrimination, the Human Rights Committee and, in two reports, the Special Rapporteur on the rights of indigenous peoples, have recommended that New Zealand increase its efforts to prevent the discrimination against Māori in the administration of justice[31]. Similar efforts are required to prevent the discrimination against Māori in the administration of health.

16. To conclude;

"Silence is Violence"- the voice of a victim recently exiting solitary confinement.

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[28] Example of a redacted District Inspectors inquiry at HVDHB's inpatient unit which includes comment on long standing transgressions with seclusion policies

[29] Example of breaches at a District Health Boards's psychiatric hospital, including systematic transgressions of seclusion policies.

[30] Office of the Director of Mental Health Annual Reports

[31] United Nations Working Group on Arbitrary Detention: Concluding Statement, 2014

APPENDIX 2:
Correspondence from ESN to 21 Regional District Health Boards

END SECLUSION NOW
PO Box 9392, Marion Square,
Wellington 6141

Email: info@endseclusionnow.com
Website: www.endseclusionnow.com

An open letter to all DHB board members

31 July 2014

Attn. NH DHB, Board Chair and Board Members
National Health Board, Ministry of Health, PO Box 5013
WELLINGTON 6145

Dear Board Chair and Board Members

End Seclusion Now is a lobby group of like-minded people working to bring about a prompt and decisive end to the use of seclusion in all of New Zealand's hospitals.

We, along with with the United Nations Special Rapporteur on Torture believe placing a person into seclusion is a breach of their human rights. It exacerbates the distress that person is already experiencing, and can leave them traumatised for many years afterwards.

We agree with the UN's position that secluding a person may constitute torture and support their call for an absolute ban on this form of solitary confinement of people with psychological disabilities.

The continuing practice of seclusion in mental health services cannot be justified or condoned. "Rising to the Challenge", the Ministry of Health's Mental Health and Addiction Service Development Plan 2012-2017 describes the intention to reduce and more importantly, eliminate seclusion. The responsibility for this is placed on all District Health Boards.

We are calling for you to support our cause to eliminate seclusion. We are asking you to respond to us and describe what your organisation is doing to bring about an end to seclusion. This can include but not be limited to, recommendations as described in the Te Pou checklist based on the 6 Core Strategies for Reducing Seclusion and Restraint. End Seclusion Now would like to be working with you to achieve the checklist goals, in particular the objective in Goal 5/7a ("*invite external service user leaders, advocates, networks and groups to provide suggestions and be involved in operations").*

We would like to showcase and support any District Health Board that is making significant progress to end seclusion. We would do this via our website www.endseclusionnow.com. We trust that you and your organisation are seeking to end seclusion in your mental health services and will join us to eliminate it completely.

We look forward to a response including information on what your organisation is doing to end seclusion.

Yours sincerely

End Seclusion Now

CONSUMERS AGAINST SECLUSION PROTEST LEAFLET

Distributed at the opening of Wellington Hospitals Mental Health 'Recovery' Unit

July 2nd 2012

Give us 'inclusion' rooms

for consumers, family/whanau, friends and consumer peers

Not 'refurbished' seclusion rooms

with their physical, psychological and chemical restraint

Consumers Against Seclusion (CAS). Contact us at: flourishing@paradise.net.nz

Leaflet endorsed by: World Network of Users and Survivors of Psychiatry (http://www.wnusp.net)
The Centre for the Human Rights of Users and Survivors of Psychiatry (http://www.chrusp.org/home)

We take this opportunity to draw your attention to our deep sorrow

You have taken a misinformed, and unilateral decision, to continue the practice of seclusion at the soon to be opened Te Whare O'Matairangi psychiatric inpatient unit. You have chosen to name it the 'Recovery Unit'. Consumers both locally, nationally and internationally are united in the belief that the recovery movement has no place for seclusion.

On behalf of the international mental health Recovery Movement, we request the reference to recovery from your facilities name be removed if it is to include seclusion rooms

If you choose to continue to practice seclusion at the new 'Unit' it will result in the involuntary confinement and isolation of people experiencing mental distress and trauma. We will see people being locked in sparse, empty rooms against their will, void of any sense of time, or facilities such as running water or a toilet. Your seclusion rooms will mean people who are in most need of sanctuary and safety will be handed over by police to mental health staff within a bare concrete delivery bay. Your seclusion rooms will mean these distressed people will be escorted straight into stark white cells, often under physical restraint, to then experience chemical restraint concluding with the inevitable psychological restraint.

Based on our experiences, this creates feelings of helplessness, punishment, confusion, frustration, fear, powerlessness, degradation and anger, that can last for many years, and which has far reaching effects. The Confidential Forum into former Patients of Psychiatric Hospitals Te Aiotanga, 2007 reported on-going effects of seclusion including fear of small and locked rooms, claustrophobia, and intense feelings of loss and dignity.

We request the refurbished 'Unit' does not have seclusion rooms based on the following evidence:

- Seclusion has no place within a humane recovery orientated mental health system
- Research does not support the practice of seclusion as a treatment or a therapy
- Seclusion is traumatizing and can lead to psychological and physical harm for the people confined, as well as staff who administer it
- Seclusion is an indication of a system failure
- International evidence demonstrates elimination of seclusion is possible and leads to positive outcomes for services and consumers
- Capital & Coast's mental health clinical development plan expects people to be "supported in home like environments"
- Seclusion is a breach of human rights

A report by the Wellington based Phoenix Consumer Group has been presented to the United Nations Convention Coalition on the Rights of People last weekend. This requested the New Zealand government amends it's mental health legislation so as not to continue to breach human rights guaranteed under UN Articles 12 and14

Seclusion has no place in modern, compassionate and effective services

We acknowledge Capital & Coast have shown some intent in the past to reduce the practice of seclusion

- Reports suggest many TWOM staff have aspirations for eventual elimination of seclusion
- If seclusion rooms exist they will be used despite the best intentions of staff
- If there are seclusion rooms, people accessing the unit will remain fearful and distrusting of the service and staff
- Director of Mental Health annual reports indicate while the number of people being secluded nationally is reducing, the average time spent in seclusion is actually increasing

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Please contact us at the earliest so we can consider your response to our request

Consumers Against Seclusion (CAS). Contact us at: flourishing@paradise.net.nz

APPENDIX 3:
NEW BUID SOLITARY CONFINEMNT CELLS, WELLINGTON PSYCHIATRIC HOSPITAL.

Solitary confinement cell

3 Cells in total

'Communal' Lounge

'Sally Port' admission entrance